



Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B Medicare for CY 2016

Summary of Key Provisions

The Centers for Medicare and Medicaid Services (CMS) published the [Medicare Physician Fee Schedule \(MPFS\) Proposed Rule for 2016](#) on July 15, 2015. This annual rulemaking proposes changes to the physician fee schedule and other Medicare Part B payment policies. This year, the proposed rule also seeks public comment on provisions related to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Medicare repeal and reform legislation passed in April of this year. CMS is asking for stakeholder input in several areas. Questions posed by the agency are **bolded** throughout the summary, for easy identification.

CMS will accept public comments on the proposed rule through September 8, 2015.

Advance Care Planning Services (ACP): CMS is proposing payment for CPT code 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family members(s) and/or surrogate); and an add-on CPT code 99498 (advance care planning including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified health professional; each additional 30 minutes (list separately in addition to code for primary procedure)). CMS is proposing to assign an "A" status indicator, which means "Active code. These codes are separately payable under the MPFS. There will be RVUs for codes with this status." CMS is proposing to adopt RUC-recommended values for these codes and will consider all public comments on this proposal. ACP services would not necessarily have to occur on the same day as E/M services. **CMS is seeking comment on the proposed codes, including whether payment is needed and what type of incentives this proposal creates.**

Merit-Based Incentive Payment System (MIPS) Input: **CMS is requesting input on the implementation of MIPS.** MIPS will consolidate the PQRS, the VBM, and the Medicare EHR Incentive Program into one reporting program, starting in 2019. Specifically, the agency is requesting input on how to determine a low-volume threshold that would be used to determine a volume of Medicare services so low that a physician or practitioner would be excluded from participation in MIPS, in addition to input on how to define "clinical practice improvement activities."

Potentially Misvalued Services Under the Physician Fee Schedule: CMS continues its identification of misvalued codes in several areas, among them codes that have experienced the fastest growth, codes that have not been subject to review since implementation of the fee schedule, codes for which there is a significant difference in payment for the same service between sites of service, and codes that account for the majority of spending in the MPFS. Table 8 of the proposed rule lists 118 codes as potentially misvalued.

In addition, **CMS is seeking recommendations from RUC and other stakeholders for the appropriate valuation of the work associated with moderate sedation before proposing a uniform approach for this service.** Appendix G of the CPT manual includes more than 400 diagnostic and therapeutic procedures that require moderate sedation.

CMS for 2015 had finalized a provision that would have transitioned all 10 and 90-day global surgery packages to 0-day global periods, but MACRA prohibited CMS from implementing this policy. However, CMS is statutorily required to develop through rulemaking a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection begin no later than January 1, 2017. The required information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate, and reported on claims, as specified by the Secretary of Health and Human Services. MACRA also authorizes the Secretary, through rulemaking, to delay up to 5 percent of the MPFS payment for services for which a physician is required to report, until the information is reported. **CMS is seeking input from the public about what kinds of auditable and objective data would be needed to increase the accuracy of the values for surgical services, so that they can improve the valuation of surgical services beginning in 2019. CMS seeks information on how postoperative visits differ from Evaluation and Management (E/M) services.**

Improving Payment Accuracy for Primary Care and Care Management Services: CMS expresses an ongoing commitment to its long-term investment in care management services through accurate payment. CMS discusses numerous initiatives the agency has undertaken over the years, including the transitional care management (TCM) code and the chronic care management (CCM) code. CMS has received requests from stakeholder regarding the need to revise the TCM and CCM code inputs to more accurately account for all of the services and resources associated with the cognitive work that primary care physicians and other practitioners perform in care planning and thinking critically about individual chronic care needs. **CMS is therefore seeking public comments on ways to recognize the resources involved in delivering needed services that go beyond what is already incorporated in the codes that describe the broader range of E/M services.** CMS is interested in codes that could be used in addition to, not instead of, the current E/M codes, and suggests that the new codes might be reported based on the resources involved in professional work, instead of the resource costs in terms of clinical staff time. The agency is requesting public comment on whether the creation of particular codes might improve the accuracy of the relative values used for such services in the MPFS. CMS will develop proposals to address these issues through CY 2016 rulemaking, with implementation in 2017.

Medicare pays for phone consultations with or about a beneficiary as part of other services furnished, but the agency is considering how to improve the accuracy of payments for care coordination for patients requiring more extensive care and they are seeking comments about how the agency can more accurately account for the resource costs of a more robust interprofessional consultation within the current structure of MPFS payment. **CMS is therefore interested in input regarding the parameters and resources involved in collaboration between a specialist and primary care practitioner within the context of current E/M services.** In addition, CMS is seeking comment on whether this kind of care might benefit from inclusion in a Center for Medicare and Medicaid Innovation (CMMI) model that would allow Medicare to test its effectiveness with a waiver of beneficiary financial liability. CMS also seeks comments on key technology supports needed to support collaboration between specialist and primary care practitioners in support of high-quality care management services.

“Collaborative Care” Models: CMS also discusses “collaborative care” models for beneficiaries with common behavioral health conditions. Collaborative care is typically provided by a primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment, as appropriate. In this model, psychiatric consultants provide regular consultation to the primary care team to review clinical status and care of patients and to make recommendations. Because this model of care has been tested and documented in the medical literature, **CMS is seeking comment on how coding under the MPFS might facilitate appropriate valuation of the services furnished under such a model, and how a code similar to the CCM code applicable to multiple diagnoses and treatment plans could be used to describe collaborative care services and other interprofessional services.** CMS also seeks input about:

- **appropriate valuation and reporting with the MPFS system and how the resources involved in furnishing such services could be incorporated into the current set of MPFS codes without overlap,**
- **whether requirements similar to those used for CCM services should apply to a new collaborative care code, and whether such a code could be reported in conjunction with CCM or other E/M services,**
- **whether and how written consent for the non-face-to-face services should be required prior to practitioners reporting any new interprofessional consultation code or the care management code,**
- **appropriate care delivery requirements for billing and other technology requirements for these services,**
- **necessary qualification for psychiatric consultants,**
- **how these services may interact with quality reporting,**
- **the resource inputs CMS could use to value the services,**
- **whether separate codes should be developed for the psychiatric consultant and the care management components of the service, and**
- **whether this kind of care model should be implemented first through a CMMI demonstration to test its effectiveness (with a waiver of beneficiary financial liability)**

Reducing Administrative Burden for CCM and TCM Services: CMS implemented separate payment for TCM services in 2013, and separate payment for CCM services in 2015. Both the service and billing requirements exceed those of other E/M services, and some stakeholders have stated that they are too burdensome. **CMS is therefore soliciting comments on steps the agency could take to improve beneficiary access to TCM and CCM services that would balance practitioner burden and access to these services so that Medicare beneficiaries will reap the full benefit of the services. CMS is also seeking objective data sources regarding the resource costs associated with furnishing the services described by the CCM code.**

Incident To Proposals: Billing Physician as the Supervising Physician and Ancillary Personnel Requirements: CMS proposes to amend the incident to regulation to state that the physician or other practitioner who bills for incident to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident to services. To clarify the meaning of this proposal, CMS is also proposing to remove the last sentence from the applicable regulation that specified that the physician, or other practitioner, supervising the auxiliary personnel need not be the same physician, or other practitioner, upon whose professional service the incident to service is based.

In addition, CMS is proposing to amend the regulation to explicitly prohibit auxiliary personnel from providing incident to services who have either been excluded from Medicare, Medicaid or any other federally-funded health care programs by the Office of the Inspector General or who have had their enrollment revoked for any reason. **CMS invites comments about possible approaches they could take to improve their ability to ensure that incident to services are provided to beneficiaries by qualified individuals, and is consistent with the Medicare statute and regulations, while being mindful of any potential administrative burden on physicians or practitioners.**

Appropriate Use Criteria for Advanced Diagnostic Imaging Services: CMS proposes to implement Appropriate Use Criteria (AUC) by establishing a process for specifying applicable AUC through rulemaking and proposing the requirements for AUC development, as required by the Protecting Access to Medicare Act of 2014.

CMS is also proposing to define the term, “provider-led entity,” in the statute so that the public has an opportunity to comment, and entities meeting the definition are aware of the process by which they may become qualified under Medicare to develop or endorse AUC. Once a provider-led entity is qualified, the AUC that are developed or endorsed by the entity would be considered to be specified applicable AUC under the statute.

Another component of the AUC program is Identification of Outlier Ordering Professionals. The identification of outlier ordering professionals under this paragraph facilitates a prior authorization requirement for outlier professionals beginning January 1, 2020. CMS is proposing to identify outlier ordering professionals from within priority clinical areas that would be established through subsequent rulemaking. CMS is proposing a process to provide clarity around priority clinical areas.

CMS is also adding a new section §414.94, “Appropriate Use Criteria for Certain Imaging Services” to its regulation. In it, CMS is proposing to codify and add language to clarify some of the definitions

previously provided and define terms that were not defined in statute but program implementation would benefit from having.

- Ordering professional - the physician or practitioner that orders that the imaging service be performed
- Furnishing professional - the physician or practitioner that actually performs the imaging service and provides the radiologic interpretation of the image
- Applicable setting - physician's office, a hospital outpatient department (including an emergency department) and an ambulatory surgical center
- Applicable imaging services - advanced diagnostic imaging services for which one or more applicable AUC apply, one or more qualified CDS mechanisms is available, and one of those mechanisms is available free of charge
- Provider-led entity - would include national professional medical specialty societies or an organization that is comprised primarily of providers and is actively engaged in the practice and delivery of healthcare

CMS also proposes adding the following to the definition of AUC for clarification purposes: "AUC are a collection of individual appropriate use criteria. Individual criteria are information presented in a manner that links: a specific clinical condition or presentation; one or more services; and, an assessment of the appropriateness of the service(s)."

Provider-led Entity AUC Development

CMS is proposing that provider-led entities become qualified by Medicare to develop or endorse AUC. These entities would have to apply to CMS, through applications accepted yearly, no later than January 1. Provider-led entities would demonstrate that they engage in a rigorous evidence-based process for developing, modifying, or endorsing AUC. Those AUC would then constitute the specified applicable AUC that ordering professionals would be required to consult when ordering applicable imaging services, the first component of the Medicare AUC program.

CMS proposes requiring a provider-led entity to demonstrate adherence to specific requirements when developing, modifying or endorsing AUC in order to become and remain a qualified provider-led entity. The requirements would be:

- an evidentiary review process for individual criteria where entities must engage in a systematic literature review of the clinical topic and relevant imaging studies
- the provider-led entity's AUC development process must be led by at least one multidisciplinary team with autonomous governance that is accountable for developing, modifying, or endorsing AUC
- a publicly transparent process for identifying and disclosing potential conflicts of interest of members on the multidisciplinary AUC development team disclosing any direct or indirect relationships, as well as ownership or investment interests, among the multidisciplinary team

members or immediate family members and organizations that may financially benefit from the AUC that are being considered for development, modification or endorsement

- each criterion that is part of the AUC that the entity has considered or is considering for development, modification, or endorsement must be maintained on the provider-led entity's website
- key decision points in individual criteria must be graded in terms of strength of evidence using a formal, published, and widely recognized methodology and posted on the website
- the process for developing, modifying, or endorsing AUC must be publicly posted on the entity's website.

Changes for Computed Tomography (CT) under the Protecting Access to Medicare Act of 2014 (PAMA) (CY 2016 only): The statutory provision requires that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable CT services were furnished that was not consistent with the NEMA CT equipment standard, and that such information be included on a claim and may be a modifier. The statutory provision also provides that such information shall be verified, as appropriate, as part of the periodic accreditation of suppliers under section 1834(e) of the Act and hospitals under section 1865(a) of the Act. Any reduced expenditures resulting from this provision are not budget neutral.

To implement this provision, CMS will create modifier "CT" (Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard). Beginning in 2016, claims for CT scans described by CPT codes 70450-70498; 71250-71275; 72125-72133; 72191-72194; 73200-73206; 73700-73706; 74150-74178; 74261-74263; and 75571-75574 (and any successor codes) that are furnished on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier "CT" and that modifier will result in the applicable payment reduction for the service.

Medicare Telehealth Services: CMS has two categories for assigning public requests for adding or deleting services to the list of Medicare telehealth services. Category 1 consists of services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. Category 2 consists of services that are not similar to the current list of telehealth services.

CMS is proposing to add the following CPT codes to the category 1 telehealth list for CY 2016:

- 99356 (prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)
- 99357 (prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)

- 90963 (end-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents)
- 90964 (end-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents)
- 90965 (end-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents)
- 90966 (end-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older).

CMS did not propose adding any services on a Category 2 basis. CMS also proposed to revise previous regulations and include Certified Registered Nurse Anesthetists (CRNA) to the list of distant site practitioners who can furnish Medicare telehealth services.

CMS is currently soliciting public requests to add services to the list of Medicare telehealth services.

To be considered during PFS rulemaking for CY 2017, requests must be submitted and received by December 31, 2015. Each request must include any supporting documentation the requester wishes be considered during review.

Technical Correction: Waiver of Deductible for Anesthesia Services Furnished on the Same Date as a Planned Screening Colorectal Cancer Test: CMS proposes a technical correction to amend existing regulations so that anesthesia services are expressly recognized as being exempt from the deductible requirement when furnished on the same date as a planned colorectal cancer screening test.

CCM Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS proposes to provide additional payment for the costs of CCM services that are not already captured in the RHC all-inclusive rate or the FQHC prospective payment system. CMS proposes that a RHC or FQHC can bill for CCM services furnished by, or incident to, a RHC or FQHC physician, nurse practitioner, physician assistant or certified nurse midwife for a RHC or FQHC patient once per month. There are similar service elements as those required under the MPFS, including 20 minutes of qualifying CCM services per calendar month to patients with two or more chronic conditions that are expected to last at least 12 months or until the death of the patient, and place the patient significant risk of death, acute exacerbation/decompensation, or functional decline. The CPT code 99490 sets forth the eligibility guidelines for CCM services and will serve as the basis for potential medical review. Table 17 of the proposed rule summarizes all of the scope of service elements and billing requirements for use of the code, and CMS invites public comment on all aspects of the proposed payment methodology and billing requirements.

CMS is seeking comment on these proposals.

Physician Compare Website: CMS is proposing recognizing the names of eligible professionals and group practices that have received an upward adjustment for the Value Modifier on the physician

compare website as well as eligible professionals that satisfactorily report the new PQRs Cardiovascular Prevention measures group for the new Million Hearts® Initiative (listed in Table 27). The 2018 Value Modifier would be based on 2016 data and posted to the site by late 2017.

CMS also proposes continuing to make all Physician Quality Reporting System (PQRS) measures available for public reporting annually, including benchmarks for PQRS measures based on PQRS performance rates using the proposed Achievable Benchmark of Care (ABC) methodology. The ABC identifies three essential characteristics: benchmarks representing a level of excellence; benchmarks that are demonstrably attainable and; benchmarks that are derived from data in an objective, reproducible and predetermined fashion. From there, with those characteristics established, providers with high performance would be selected from among all providers in a predefined way using reliable data and all providers with high performance levels would contribute to the benchmark level. Providers with high performance levels but small numbers of cases would not unduly influence the level of the benchmark.

CMS also proposes making both individual and group level QCDR measures available for public reporting. CMS has also proposed publicly reporting utilization data for eligible professionals in the downloadable database. The agency would also like to include Value Modifier tiers for cost and quality; notations of the payment adjustment received based on the cost and quality tiers; and indications of eligible professionals or group practices' eligibility for, but non-reporting of, quality measures in the downloadable database. **CMS is seeking public comments on adding Medicare Advantage data and Value Modifier cost and quality data to the Physician Compare website.**

PQRS: For 2016, CMS proposes to add measures to address existing gaps, and eliminate measures that are topped out, redundant, or being replaced. If all of the proposed changes to measures are finalized, there will be a total of 300 measures for PQRS in 2016 (see Tables 20-29 of the proposed rule). **CMS seeks public comment on any of the proposed changes to quality measures.** If an eligible professional (EP) or group does not satisfactorily participate in the program in 2016, they will receive a payment adjustment of 2% in 2018, i.e., 98% of the MPFS amount on Part B services. Due to the implementation of MACRA's Merit-Based Incentive Payment System (MIPS), which will consolidate PQRS, the Medicare EHR Incentive Program, and the VBM into one reporting program, 2018 will be last year of payment adjustments under PQRS.

Electronic Clinical Quality Measures (eCQM) and Certification Criteria and Electronic Health Record (EHR) Incentive Program— Comprehensive Primary Care (CPC) Initiative and Medicare Meaningful Use Aligned Reporting: CMS is proposing to revise the CEHRT definition for 2015 through 2017 to require that EHR technology is certified to report CQMs in the format that CMS can electronically accept if certifying to the 2015 Edition "CQMs – report" certification criterion. This would apply for EPs, eligible hospitals, and CAHs. CMS is also proposing the same revision for 2018 and beyond. **CMS is seeking comment on this proposal.**

Electronic Health Record (EHR) Incentive Program-Comprehensive Primary Care (CPC) Initiative Aligned Reporting

CMS proposes to retain the group reporting option for CPC practice sites as finalized in the CY 2015 PFS final rule, but for CY 2016, to require CPC practice sites to submit at least 9 CPC CQMs that cover 3 domains. CMS is also proposing that for CY 2016, EPs who are part of a CPC practice site and are in their first year of demonstrating meaningful use may also use the CPC group reporting option to report their CQMs electronically instead of reporting CQMs by attestation through the EHR Incentive Program's Registration and Attestation System. EPs that choose this CPC group reporting option must use a reporting period for CQMs of one full year, and not 90 days, and that the data must be submitted during the submission period from January 1, 2017 through February 28, 2017.

- **Provision of data feedback to practices** - CMS seeks comment about how it can best provide actionable data to support quality improvement and promote attention to total cost of care under a potential expansion.

CMS may modify existing models or test additional models under its testing authority while taking into consideration stakeholder input.

Potential Expansion of the Comprehensive Primary Care (CPC) Initiative: **CMS is soliciting public comments in order to receive information about issues surrounding a potential expansion of the CPC initiative including:**

- **Practice readiness** – CMS seeks to understand the proportion of primary care practices ready for transformation expectations and whether readiness varies systematically for differently structured practices (for example, small primary care practices, multi-specialty practices, and employed primary care practices within integrated health systems)
- **Practice standards and reporting** – CMS seeks input on the value and operational burden of the current CPC Milestones approach, including the current system of quarterly reporting via a web portal
- **Practice groupings** – CMS seeks input as to whether any potential expansion should be limited to existing CPC regions, or include new geographic regions. CMS is also interested in whether multi-site group practices would be willing to involve all their primary care sites in a potential expansion of the CPC initiative and how practices could best be grouped for the purposes of calculating shared savings
- **Interaction with state primary care transformation initiatives** – CMS is interested in whether a potential expansion of the CPC initiative could and should exist in parallel in a state with a separate state-led primary care transformation effort, especially if Medicare is participating in that effort
- **Learning activities** - CMS is interested in what support practices would require to provide the five comprehensive primary care CPC functions in a potential expansion of the CPC initiative, and the readiness of the private sector to respond to the need for this support as well as the willingness and ability of existing state and regional primary care or patient centered medical home learning collaboratives to support practices in an a potential expansion of the CPC initiative

- **Payer and self-insured employer readiness** – CMS seeks input on the readiness of currently participating payers in the CPC initiative to expand their current investment in CPC and the readiness of new payers, including self-insured employers, to enter the initiative under a potential expansion
- **Medicaid** – CMS is interested in whether state Medicaid agencies would be willing to participate in a potential expanded CPC initiative for their fee-for-service enrollees and whether Medicaid managed care plans would be willing to participate in a potential expanded CPC initiative
- **Quality reporting** - CMS is interested in comments on practice readiness to report eQMs, and payer interest in using practice site level data rather than their own enrollees' information for performance based payments, including shared savings, in a potential expansion of the CPC initiative
- **Interaction with the CCM fee** - CMS seeks input on how payment for CCM services might interact with a potential expansion of the CPC initiative and affect practice interest in participation

Medicare Shared Savings Program (MSSP): CMS is proposing some provisions related to the MSSP, including the proposal to add the Statin Therapy for the Prevention and Treatment of Cardiovascular Disease to the Preventive Health Domain, which will align with PQRS. The agency also proposes to preserve the flexibility to revert quality measures to pay for reporting if they no longer align with current clinical practice or could cause patient harm. The agency also takes the opportunity to clarify how PQRS eligible professionals within an accountable care organization (ACO) can meet their PQRS reporting requirements when the ACO satisfactorily reports. And lastly, CMS proposes to amend the definition of primary care services to include claims submitted by Electing Teaching Amendment hospitals, and exclude claims submitted by Skilled Nursing Facilities, and **requests public comment on these proposals.**

Value-Based Modifier (VBM): CMS makes multiple proposals affecting the application of the VMB and proposes the continued application of the VBM based on performance periods two years prior, i.e., application of the 2018 VMB will be based on calendar year 2016 participation in the PQRS. CMS also proposes to apply the VMB to nonphysician EP groups to include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and nonphysician solo practitioners beginning with the calendar year 2018 payment adjustment period. CMS also plans to apply the quality-tiering methodology to all groups and solo practitioners that satisfactorily report PQRS for the calendar 2018 payment adjustment period, except for groups consisting only of nonphysician EPs and solo nonphysician practitioners, who be held harmless from downward adjustments under the quality-tiering methodology in calendar year 2018. CMS also plans to waive application of the VBM for groups and solo practitioners if at least one EP billed through the MPFS participated in the Pioneer ACO Model, CPCI, or other similar CMMI model during the performance period. **CMS is open to public comments on all of these proposed policies.**

Physician Self-Referral: CMS proposes changes to the Stark physician recruitment provisions that would make it easier to recruit nonphysician practitioners (NPPs) to Federally Qualified Health Centers (FQHCs)

and Rural Health Clinics (RHCs). The new exception would permit hospitals, FQHCs, and RHCs to offer remuneration to NPPs to help address primary care workforce shortages. CMS proposes to cap remuneration at the lower of 50% of the actual salary, signing bonus, and benefits paid to the NPP or an amount calculated by taking the receipts of services provided by the NPP, less the actual salary, signing bonus and benefits paid to the NPP. An NPP must also meet certain qualifications, i.e., be a bona fide employee of the physician or practice, and provide primary care 90 percent of the time. **CMS seeks public comment on whether the proposed exception should be extended to more types of practitioners, and whether the proposed caps are adequate.** For physician-owned hospitals, CMS proposes to clarify the disclosure requirements regarding public notification of physician-ownership on the public website of the hospital. CMS clarifies that social media outlets, health information exchanges, and electronic patient care portals do not meet the definition of a hospital's "public website." CMS also clarifies that the disclosure statement must be displayed in a clear and readable manner in a size that is consistent with other content on the website, but does not designate a font size. CMS also clarifies the timeframes for when the Self-referral Disclosure Protocol (SRDP) submissions apply. For the public website of the hospital requirements a period of non-compliance would be the period during which the physician-owned hospital failed to satisfy the notification requirement, and for the public advertising for the hospital it would be the duration of the applicable advertisement's predetermined initial circulation, unless the hospital amends the advertisement to satisfy the requirement at an earlier date. **CMS seeks public comment as to whether the clarifications are adequate.**

Physician Opt-Out: MACRA established new Medicare physician opt-out procedures, stating that opt-out affidavits filed on or after 60 days following the date of the law's enactment (April 2015) will automatically renew every two years. Physicians and practitioners are able to rescind their opt-out status if they notify CMS at least 30 days prior to the start of the next two-year period.